**STATE OF MICHIGAN**

**DEPARTMENT OF LABOR & ECONOMIC GROWTH**

**OFFICE OF FINANCIAL AND INSURANCE SERVICES**

**Before the Commissioner of Financial and Insurance Services**

**In the matter of**

**XXXXX**
**Petitioner** **File No. 85783-001**

**v**

**Priority Health**
**Respondent**
_____/

**Issued and entered**
**this 17th day of December 2007**
**by Ken Ross**
**Acting Commissioner**

**ORDER**

**I**
**PROCEDURAL BACKGROUND**

On October 17, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of the Office of Financial and Insurance Services (Commissioner) under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. After an assessment of the material submitted, the Commissioner accepted the request on October 24, 2007.

The Petitioner had health care coverage from Care Choices, a health maintenance organization (HMO). On March 27, 2007, Care Choices surrendered its certificate of authority and is no longer licensed to conduct business as an HMO. Priority Health acquired Care Choices' assets and liabilities and now underwrites Care Choices' coverage. Priority Health handled the Petitioner's grievance and is the Respondent in this external review.

The case required analysis by a medical professional. Therefore, the Commissioner assigned the matter to an independent review organization (IRO) which submitted its recommendation to the Commissioner on November 2, 2007.

## II
## BACKGROUND

The Petitioner sought approval from Care Choices (hereinafter Priority Health) for gastric bypass (bariatric) surgery. Priority Health denied the request, saying the Petitioner did not meet the criteria of its medical policy.

The Petitioner exhausted Priority Health's internal grievance process and received its final adverse determination letter dated August 28, 2007.

## III
## ISSUE

Did Priority Health properly deny the Petitioner's request for authorization and coverage for bariatric surgery?

## IV
## ANALYSIS

PETITIONER'S ARGUMENT

The Petitioner says she weighs 255 pounds, is 5'5" tall, and has a body mass index (BMI) of 42.4. She says that over the last thirteen years, she has tried every low fat diet (Atkins, cabbage soup diet, and Weight Watchers, etc.). She has also made multiple attempts to lose weight with pharmacotherapy (diet pills and Redux), hypnosis, laser treatment, and acupuncture, all without success.

The Petitioner says her obesity has caused many adverse health problems including diabetes, degenerative joint disease, and hyperlipidemia. She is currently taking medications for high cholesterol and back pain; she also sleeps with a C-PAP machine.

XXXXX, MD, the Petitioner's primary care physician (PCP), supports her request for surgery. In a letter dated October 11, 2007, Dr. XXXXX wrote in part:

> [The Petitioner] has exhausted all medical means of trying to lose weight and understands that her medical problems continue to worsen with her persistent weight problems. At this point in her life, she has decided to live a healthier life and has made a

> commitment to losing weight and gastric bypass surgery. Without this surgery, [her] health will continue to deteriorate and she will suffer a premature death from weight-related medical problems.

The Petitioner believes, as does her physician, that she needs bariatric surgery now. She thinks the surgery is medically necessary and is concerned that if she does not lose weight her quality of life will be further affected and she will develop even more serious health problems.

PRIORITY HEALTH'S ARGUMENT

Weight reduction procedures are a covered benefit under the terms of the Petitioner's subscriber certificate when certain conditions are met. In section 5.22 of the certificate it says:

> Surgical treatment of obesity is covered when the Member's condition meets HMO's then current chronic obesity guidelines and the proposed procedure is approved in advance by HMO under those guidelines, including any applicable co-payments or deductibles.

The obesity guidelines Priority Health uses to establish medical necessity come from Care Choices medical policy MS-10, entitled "Bariatric Surgery," which says in part:

> Members may receive surgical intervention for chronic, severe and resistant obesity that has not improved or responded to a 12-month weight management program (as specified below) and when **all** of the following criteria are met:
>
> 1. Must be at least 18 years of age.
> 2. The member has undergone evaluation to rule out other treatable causes of morbid obesity.
> 3. BMI ≥40 with or without co-morbid conditions
>    or
>    BMI ≥35 and <40 and two weight-related life threatening co-morbidities, as outlined below. Members must be compliant with the prescribed treatment for these co-morbid conditions.
>
>    Co-morbidities include:
>    - Diabetes mellitus with inadequate glycemic control despite maximal medical management.
>    - Symptomatic sleep apnea not controlled by C-PAP
>    - Severe cardio-pulmonary condition

- Hypertension inadequately controlled with maximal medical management
- Uncontrolled hyperlipidemia not amenable to maximal medical management

4. Office records from the PCP document compliance with a weight loss program that monitors and regularly documents, in office progress notes and records, weight and weight-related conditions (such as diabetes, hypertension and hyperlipidemia). Thorough documentation by the PCP at each office visit, is required and must be submitted for review. The documentation must show:
    - The weight loss program was actively supervised by the PCP, for a minimum continuous duration of 12 months, and included diet and exercise
    - At least 6 office visits during the continuous twelve-month period in which the obesity and weight-related conditions are addressed in the PCP's progress notes and records
    - For each of the 6 visits the progress notes and or records include the following regarding the obesity problem:
        iv. An actual measured weight
        v. The patient's history
        vi. The physical finding
        vii. The physician's assessment
        viii. The physician's treatment recommendation(s)/plan(s)

    1. Reference to at least one session of behavioral modification therapy, focused on the obesity problem, by a qualified mental health professional.

    This criterion is fulfilled only after failure to make good progress (in accordance with the NHLBI panel recommendations) subsequent to documented compliance. A physician's summary letter of care provided is insufficient documentation. Past weight loss attempts without physician supervision through such programs as Weight Watchers, Curves, personal trainers, etc., are insufficient to meet the criteria above. Detailed records of participation and progress in a nutrition and exercise program supervised by a physician other than the PCP (e.g. Medifast, HMR, Optifast etc.), may be submitted for review to supplement the PCP's records. The Medical Director will review each case on an individualized basis to determine compliance with this policy section. * * *
5. A psychological/psychiatric evaluation must be performed by a psychiatrist or a mental health professional in order to establish the member's ability to, and intent to, comply with post-surgical limitations, behavioral and lifestyle modifications. In addition the evaluation should determine if there are any

> psychiatric or psychological contraindications, including active substance abuse or psychopathology that would affect informed consent, and it should address any unique psychiatric or psychological issues that should be addressed prior to or after surgery. Members who have a history of severe psychiatric disturbances (schizophrenia, borderline personality disorder, suicidal ideation, severe depression etc.), or who are currently under the care of a therapist/psychologist/psychiatrist, or who are on psychotropic medication may be unable to provide informed consent. In addition, they may be at increased risk for noncompliance pre and postoperatively. A Care Choices Medical Director will determine, on a case-by-case basis, if the psychological evaluation submitted meets the criteria and intent of this Policy section. * * *
> NOTE: The presence of depression due to obesity is not normally considered a contraindication to obesity surgery…

Priority Health explained its denial of coverage in its October 25, 2007, letter to OFIS:

> The…Priority Health Medical Policy No. MS-10 for Bariatric Surgery outlines the medical criteria that are required to be met for coverage of bariatric surgery, including compliance with a weight loss program that monitors and regularly documents, in office progress notes and records, weight and weight-related conditions. Clinical information reviewed does not indicate that [the Petitioner] has attended and been in compliance with a weight management program as previously stated. Based on the facts stated above…Priority Health has determined [the Petitioner] does not meet the required medical criteria for coverage of bariatric surgery.

COMMISSIONER'S ANALYSIS

Priority Health denied coverage because it believed the Petitioner had failed to meet a criterion of its medical policy: specifically, participation in a physician-supervised and monitored weight loss program for a minimum of a continuous twelve months. The Petitioner's medical records were submitted to an IRO to evaluate that issue. The reviews were conducted by two physicians.

The first reviewer is an internist certified by the American Board of Internal Medicine and is a member of the American College of Physicians. The IRO internist noted that Priority Health's medical policy defines the criteria which must be met in order for surgery to be

approved. The IRO internist concluded that bariatric surgery is not appropriate for the Petitioner at this time because she did not document participation in a physician-supervised weight loss program for twelve months. The IRO internist also observed that there is support in the medical literature for the requirement in Priority Health's medical policy that its enrollees complete a weight loss program before bariatric surgery is approved.

The second IRO reviewer is certified by the American Board of Surgery, a member of the American Medical Association, and is in the active clinical practice of general surgery. The IRO surgeon recommended reversing Priority Health's denial of bariatric surgery. The IRO surgeon said the Petitioner had tried and failed various weight loss programs for the last ten to 12 years and commented:

> Weight loss by dieting in morbidly obese individuals is extremely ineffective; at five (5) to ten (10) years after initiating a weight reduction program less than two (2) percent of patients lose more than 50 % of their excess body weight. Very low calorie diets and pharmacologic supplementation have not shown to be effective in the long term.

The IRO surgeon did not make a determination about whether or not the Petitioner had completed a physician-supervised weight loss program for 12 months. Instead, the IRO surgeon offered the opinion that Priority Health's medical policy on bariatric surgery was "not in accord with the Consensus Statement of the American Society of Bariatric Surgery" because it mandated completion of a 12-month weight loss program before surgery. The IRO surgeon further concluded that bariatric surgery was medically necessary for the Petitioner.

Priority Health determines eligibility for weight reduction surgery by using criteria in its medical policy. Under that policy, its enrollees must participate in a physician-supervised weight loss program as described in criteria 4 of the policy quoted above. Notwithstanding the opinion of the IRO surgeon, the Commissioner finds that Priority Health's medical policy is both reasonable and acceptable. Participation in a medically-supervised 12-month weight loss program that includes diet, exercise, and behavioral modification is appropriate for individuals

requesting bariatric surgery. Bariatric surgery is not without significant inherent risk, and any effort to reduce that risk is beneficial. Such a program also prepares the patient for the restricted diet that is necessary after surgery. The IRO internist pointed out that support for dietary management prior to obesity surgery finds support in both the 2004 consensus statement of the National Institutes of Health and the Milliman Care Guidelines.

It was the opinion of the IRO internist, after reviewing the medical records, that the Petitioner had not shown that she had met the requirement of a 12-month physician-supervised weight loss program. The Commissioner has also looked at the medical records and similarly concludes that the Petitioner has not met Priority Health's criteria. The records document five office visits over only 12 months, and bariatric surgery was mentioned only at the January 2007 visit. The records seem to address health concerns other than weight loss and do not constitute the kind of physician-supervised weight loss program described in the medical policy: there is no documentation of physical exercise, diet therapy, or behavioral therapy. While the Petitioner has tried numerous weight loss programs over many years without success, those programs do not comply with the approach outlined in Priority Health's policy.

The Commissioner accepts the opinion of the IRO internist and finds that the Petitioner does not qualify for bariatric surgery at this time because she has not completed a 12-month, physician-supervised weight loss program as outlined in Priority Health's policy.

## V
## ORDER

The Commissioner upholds Priority Health's August 28, 2007, final adverse determination in the Petitioner's case. Priority Health properly denied the Petitioner authorization and coverage for bariatric surgery at this time under the terms of her coverage.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court

of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.